International Hospital Federation

FULL MEMBERSHIP APPLICATION FORM 2019

I certify that all the information and accompanying material provided in connection with this application are authentic and accurate.

Date: _____ Signature: _____

2. GENERAL DETAILS

Organization Name: _____

Address: _____

Country: _____ Website: _____

Phone: _____ Fax: _____

Contact person:

Name: _____ Position: _____

E-mail: _____ Phone: _____

3. YOUR ORGANIZATION

Nature of your organization and information on your activities

☐ **Hospital Association** (Please specify N° of affiliates _____)

- N° of establishments _____
- Total N° of beds _____
- Total N° of staff _____
- Total annual turnover _____

☐ **Healthcare Authority Association**

- Total N° of members _____
- Total N° of staff _____
- Total annual turnover _____

☐ **Ministry of Health**

- N° of facilities _____ (of which hospitals _____)
- Total N° of beds _____
- Total N° of staff _____

☐ **Other** (please specify)

_____

4. STATUS OF YOUR ORGANIZATION

☐ **Public**

☐ Fully autonomous ☐ Partial autonomous ☐ Related to MoH

☐ Related to Regional/State government ☐ Related to town/cities

☐ Other

☐ **Private** ☐ For profit ☐ Non for profit

5. ADDITIONAL CONTACTS

Mail address and name of your **communication manager**:

Mail addresses of people who would be interested in receiving the electronic **newsletter**:

6. ANY OTHER INFORMATION

You can provide additional information to Sara Perazzi, IHF Membership and Project Manager:
E-mail: sara.perazzi@ihf-fih.org
Telephone: +41 (0) 22.850.94.20